MEDICARE PAYMENT ADVISORY COMMISSION

PUBLIC MEETING

Ronald Reagan Building
International Trade Center
Horizon Ballroom
1300 13th Street, N.W.
Washington, D.C.

Thursday, September 9, 2004
10:36 a.m.

COMMISSIONERS PRESENT:

GLENN M. HACKBARTH, Chair
ROBERT D. REISCHAUER, Ph.D., Vice Chair
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FRANCIS J. CROSSON, M.D.
AUTRY O.V. "PETE" DeBUSK
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MARY K. WAKEFIELD, Ph.D.
NICHOLAS J. WOLTER, M.D.

AGENDA ITEM:

Measuring quality in home health
-- Sharon Cheng

MS. CHENG: This afternoon I am going to be addressing measuring quality in home health. I'm going to power-walk us through some background slides and our criteria for judging the feasibility of measuring quality in a sector. Then I'm going to spend most of my time on looking at the home health sector specifically and the measures sets that we have available and identified for this sector.

I think we have hit a lot of this in the previous sessions so I'm not going to go into it. MedPAC has found the current system, generally speaking, to be neutral or negative toward quality, so our agenda has developed, taking its first step in June 2003, after we surveyed a number of private plans that had come to the same conclusion really. We asked what they were doing and what direction they were moving and found that they were taking the step of linking performance to payment. We recommended that Medicare consider this strategy.

We established then criteria that we felt applied specifically to Medicare and was based on the experience of these private payers, but a set of criteria we would use for determining which settings within Medicare were ready to take this step. Then in March 2004 we found two settings, dialysis physicians and facilities, and Medicare Advantage plans, were ready for this step and met our criteria.

The criteria that we developed are the four you see here. We felt it was important for a given setting there be a set of well-accepted evidence-based measures. By that we mean we would like to see a set that the providers that were going to be scored on this and paid on this would be familiar with them before they saw their payments change. By evidence-based we mean reliable and valid. And for process measures specifically, we mean that there is evidence that suggests if we are going to incent a process that we've got scientific backing that that process is going to lead to improved outcomes of care for the beneficiaries. And for outcome measures, along the lines of what Senator Durenberger suggested, we want to hold the right entity responsible for the quality that we're measuring.

Our second criterion is that there be a standardized mechanism for data collection. There are a couple of thoughts here. We want to make sure that the burden is not undue on either end of the pipeline, so that it is something reasonable for the providers to do and it's also reasonable for CMS to do. They cannot process a bunch of unstandardized data that comes in. We need to make sure that the process is not an undue burden on either end.

We also are looking for standardized data collection so that we have an assurance that we're getting something consistent. We want to ask the same question and get the same answer as often as we can from the providers that we're measuring.

For risk adjustment, our criterion is that we have adequate risk adjustment. In some cases perhaps we might find that risk adjustment is not as necessary. For example, maybe a patient experience measure of a process measures that is not likely to be affected by the case mix of the patients that the provider is caring for.

Or in the case of outcome measures, we want to make sure that we have adequate risk adjustment for two reasons. We certainly want to make sure that as we set up this incentive we're being equitable to the providers that we are measuring. And we also want to make sure that we don't develop or cause an access problem. If a provider feels that they can improve their score and improve their payment by denying care to a patient that might benefit from that care but is not likely to get a terrific outcome, we want to make sure that we've got something that is doing to take that into account.

Finally, we are after a set of measures the providers can improve upon. This goes back to the idea of holding the right entity responsible. But it also goes to an idea that I think brings all four of these together, which is if we go to measuring quality and attaching payment to it, what we want is to make sure we have identified things where making an improvement is going to affect the care of a number of beneficiaries. We'd like to get a lot of beneficiaries, and we'd like to make a substantial change. We're not so interested in moving from 98 percent compliance to 99 percent compliance. We'd rather go for something where maybe the compliance is 60 percent and get that up to 70 percent or 80 percent.

So in home health we've identified four indicator sets that we'd like to explore to determine whether or not it's feasible to move the agenda in this setting. The four indicator sets are the outcomes-based quality improvement set, OBQIs, the outcome-based quality monitoring set, the OBQMs, assessing care of vulnerable elders, the ACOVE set, and patient experience surveys.

OBQIs are a set that are comprised of nine measures of improvement or stabilization in activities of daily living, such as what percent of patients who could improve, did improve in their ability to bathe during their home care episode? There are 12 measures in the set of instrumental activities of living, such as a patient's ability to do their own laundry, 14 measures of clinical improvement or stabilization, such a shortness of breath or the frequency of confusion, and there are three utilization measures, such as the use of emergency care during the home care episode.

In terms of familiarity, the OBQIs have some strength here because they're currently in use in the Medicare program. In fact the OBQI set pre-dates the PPS payment system that we're using right now, and in this setting, the idea that measuring quality and monitoring it has been one that has been on the forefront of development here for actually about 10 or 15 years. The OBQIs are used in the Medicare system currently in reports that flow back to the home care agencies so that they have an idea of their performance and can benchmark it against peers. It's also used on a web site that allows consumers to make

choices among home care agencies called the Home Care Compare web site. So it's publicly reported data.

We have heard some concerns about the reliability and the validity of the measures in this set. I would like to address those concerns head-on in just a moment, and also right now, discuss a little bit of the research that we have on this. We have two studies that have looked at reliability and validity. In the first study we have a measure of the inter-rater reliability of OASIS. That's the tool that they're using to derive the OBQI. The researchers compared two nurses who were looking at the same patient to find what level of congruence they got on taking this tool twice. They found that the level of congruence on the items that we're talking about here was between 60 and 80. As we looked across health services research that was generally felt to be good or very good.

In terms of validity we also have another group of researcher that asked, what we are measuring, is that congruent with the patient's own assessment? So they compared nurses and therapist assessment of patients with their own self-reported ability on activities of daily living and instrumental activities. Here again they found a level of congruence of about 60, which we might characterize as a good level of congruence. So it speaks to the validity of the data that we're deriving the OBQIs from.

MR. DeBUSK: May I ask, you are getting some coherence or what have you in comparing the data, the collection of data. Did all this come out from the OASIS assessment system?

MS. CHENG: The OBQIs are derived from the OASIS system, that's right.

MR. DeBUSK: Now how long does it take to fill out an OASIS report?

MS. CHENG: We have heard estimates -- OASIS has been used in the field now since 1999. When it came out, we understood that it was taking nurses and therapists over two hours in the field to complete this tool. We have heard anecdotally, and I don't have a study on this, since 1999 we've been doing this on every patient that Medicare has paid for, so I think that the time it takes has become more integrated in the plan of care in what a nurse would normally do during that first visit. So it might be taking some time but it is also regarded as a pretty integrated part of assessing the patient and planning their care.

MS. RAPHAEL: I think it takes an hour or about an hour and-a-half to do it generally. That would be the average amount of time. It's a 29-page document.

MS. CHENG: We also have some evidence on the reliability and the validity of the OASIS from two other groups that have looked at this set. The first group that I'd like to talk about is the National Quality Forum, and I would like to again mention as I speak about their work, we are relying currently on work that they have done in a preliminary fashion. The National Quality Forum has not yet formally endorsed or given their final rating to these measures. But according to the work that they have done up to this point, they gave their highest rating for validity and reliability to 18 measures from the OBQI set.

Another group that's looked at this set is the Agency for Healthcare Research and Quality, and they went through a similar system of looking at reliability and validity and the feasibility of measuring these, and also whether or not they made sense, because AHRQ was also concerned about the public reporting. AHRQ id endorse 14 of the OBQI measures. The other good piece of news here is that there's some congruence between those two groups and they endorsed 10 of the same measures from this set.

These indicators, as I mentioned in response to Pete's question, are derived from the OASIS assessment tool, so we already have a standardized tool that's currently being used in the field and being collected by CMS for this set.

Risk adjustment is available for the OBQI outcomes. The University of Colorado is a group that developed the risk adjustment for this set. For some of those outcomes they are able to apply up to 50 different patient characteristics to determine the expected outcome for that patient. In addition to the usual suspects that you would look for in just about any risk assessment, we've got diagnosis, age, and sex. But because of the richness of the OASIS tool, we're also able to apply patient prognosis, functional limitations of the patient currently, the presence of a caregiver informally to support that patient in their home, and some cognitive and behavioral information.

We have some evidence that there is room for improvement and that this is under the power of the home health agencies to improve. We have had two measurement periods now for the publicly reported Home Care Compare, and we found small but consistent improvements in the level of performance on the OBQI set.

The next set I would like to bring to you is the OBQM set. You can see from the examples how they're a little different from the OBQIs. An example of an OBQM might be, what percent of patients used emergency care from injury caused by a fall or an accident? What percent of patients had an increased number of pressure ulcers? Or what percent of patients were discharged to the community at the close of their care who still needed assistance with toileting?

Like the OBQIs, the OBQMs are currently being used in the Medicare program and are similarly derived from OASIS data, so the observations that I've made about OASIS as a tool apply here. In addition to being derived from OASIS, the OBQIs would have the possibility or the potential to be audited from other sets because they also address contacts with other parts of the home care system, so we could audit this by looking at ER use for beneficiaries, or we could audit it perhaps by looking at physician visits and the nature of physician visits.

The OBQMs are less frequent, which is a very good, than the OBQIs, because they are adverse events. They don't happen to most patients. Because they are far less frequent, the risk adjustment that we have for these are less available. They do, however, have a risk adjustment system in the sense that we've measured their frequency and we can gauge age, sex, and perhaps diagnosis -- maybe not -- on the likelihood of the expected rate of some of the events in this set.

One important difference between the OBQIs and the OBQMs is that in both sets we have those utilization measures. Did somebody who was under the care of a home health agency go to the ER, or go to the hospital during their stay? The OBQMs have a little bit of a differentiation because they are trying to only count hospitalizations or ER use that follow what is called a sentinel event. So perhaps this use of the hospital or the ER is more indicative of quality than would be a measure of any use of a hospital ER. The sentinel events would be an injury caused by a fall or an accident at home, a wound infection or a deteriorating wound, improper medication administration, side effects, or toxicity of medications, or diabetes out of control.

My final point on the OBQMs, here too we have some evidence that there is room for improvement and the capability to improve. Both a study by Shaughnessy and our own work with the national database concur that home health agencies can improve their performance on measures in this set. For example, though the rates were small, both studies found a decline over time in the rate of hospitalization for home health patients.

The next set are the ACOVE measures. This is again a somewhat different set. Examples of this would be whether or not the home health agency evaluated reversible causes of malnutrition. Did a professional of the agency ask a patient about falls? Was the patient screened for alcohol use? And did the home health agency document advance directives, care surrogates, or preferences for end-of-life care? The developers of the ACOVE set believe that the medical system generally places too great an emphasis on treatment and too little emphasis on taking thorough histories or providing preventive care. Thus, they felt that the processes that they have identified here could have a significant impact on improving the quality of care.

ACOVE up to this point, unlike the OBQMs or the OBQIs has only been used really in the research setting. It is not currently in the field, nor is it widely used in home care. The National Quality Forum has looked at the ACOVE measures and found the evidence base for these measures was good for the set of measures that they deemed applicable to home health. ACOVE is actually a very large set for assessing care of elders in many different settings with about 207 measures, but only a subset of them apply to home health. The NQF gave seven of the measures from ACOVE their highest rating for reliability, validity, and feasibility.

The ACOVE, also unlike OBQIs or OBQMs, doesn't run from administration data. It's derived from medical records. It's a very detailed set, and definitions really try to hone in on processes. But because of that it would not be possible to run this set from administrative data that we have now. For example, the fall ACOVE indicator is defined as whether a patient reports two or more falls in the past year or one fall that required medical care. And then if that is available from the records, then did that patient receive an evaluation for falls. So it is a pretty narrowly defined and precisely defined set.

We do have a study that suggests that there is room for improvement in the measures that we are taking here in ACOVE.

Wenger studied two large groups of elders in managed-care organizations and found that vulnerable elders received appropriate treatment an encouraging 81 percent of the time once they were ill or injured. However, they often did not receive other indicated medical care. Wenger found that 63 percent of patients received the follow-up that would be indicated from the medical records, only 46 percent of them received appropriate diagnostic care, and 43 percent received preventive care that would have been indicated.

The final set that I would like to discuss is patient experience. Some examples of patient experience could be, did you know what to expect from your home care agency for the episode of the care? Do you understand how to operate medical equipment that is in your home? Or how often were you and your family adequately involved with decisions regarding your care? These would all be measures of the patient's experience of home care.

They are a familiar sounding set and they might be similar to patient satisfaction questions that you might see perhaps for a doctor's visit. But one distinction that you might make here is that while a doctor's visit would affect a patient's experience for an hour, and hour and-a-half in a day, a patient might be in contact with their home health agency for several weeks, simple months, or the balance of a year. So this experience is actually going to be measuring something that's a contact with a patient for a long period of time.

Satisfaction surveys are common, we understand, throughout home health agencies but there is no single public tool that measures satisfaction and we do not have research on patient experience. So satisfaction might be questions more like, were you satisfied with your home care agency? Experience, such as the questions that we just talked about, we really do not have much research on at all. We do know that satisfaction ratings for home health agencies are consistently very high. Certainly encouraging, but it means there isn't much variation if we're trying to differentiate among different home health agencies. One researcher that looked at this satisfaction question in the Journal for Healthcare Quality found that though there are consistently high satisfaction ratings, questions such as the one that we suggested on the previous slide, might yield a little bit more variation than we see in just satisfaction globally and might identify areas where there would be room for improvement.

Now I would like to talk just a little bit about where we are staff-wise on this research. One of the things that we have done and will do over the next several weeks or months is to talk to the provider community about these sets and their experiences with them and their reactions to them. So far as we've spoken with representatives of the industry we have heard concerns that nurses, therapists and other professionals in the field still have questions about how to use OASIS, and some feel that they still haven't mastered the tool in a reliable, consistent fashion. The tool is being continuously clarified, updated and tweaked by CMS so it is undergoing changes to improve the tool,

so it's not the same tool that it was four years ago.

We also heard some hesitancy as we discussed the ACOVE measures that I think I might characterize as largely driven by unfamiliarity with the ACOVE measures, although we did get a positive response about considering process measures in this area. We also heard concerns that the same goals for improvement and recovery that might be relevant to somebody recovering from an acute illness or injury would not be the same as the goals of care for a chronic patient, so they felt that as we look at sets and especially if we were to move toward identifying a set upon which they were going to be paid, we should try to get measures that would encompass a lot of the different goals and the different kinds of care that's going on in the home care setting.

We've spoken with researchers, we've looked at preliminary work by NQF and AHRQ, and these groups have identified issues with reliability and validity for some indicators in all of the measure sets that we've spoken about here this morning. But there does just seem to be a consensus that is forming, and perhaps a subset of these indicators across some of these measure sets, that are viewed as generally valid, reliable and feasible.

We will also continue our work on process measures. In the course of doing the work to prepare for this meeting we have run into some groups that we understand are currently working on other process measures, and one of those groups that we would like to talk to in fact is the Center for Home Care Policy that we understand is working on looking at processes of care. So we're going to continue to look in that area and see what else we can find for process measures.

At this point staff seeks the Commission's guidance on this topic, and specifically the question that we opened with, is it feasible to make valid comparisons with the measure sets that we have available of home health agencies, and where does this sector fit into our agenda on quality?

MS. RAPHAEL: I think you've done a very good job of giving us this state of the union for home health care quality measurement at this point. I think that the Commission ought to be aware that this is a period where CMS is looking at OASIS and refining it and taking it to the next generation. There is a lot of work going on around that which Sharon has tried to capture.

I think some of the most important work that we need to await the results of has to do with the risk adjuster. I'm not expert in this area but I think there are questions about the risk adjuster. One has to do with the ability to prognosticate. I guess it's somewhat akin to what we have found with hospice and end-of-life care, that physicians do not necessarily do a good job of giving us the prognosis.

Second set of issues has to do with long-stay versus short-stay patients. If you are dealing with someone who is a paraplegic and is in his thirties or forties we find that the outcomes are very different than someone who is a short-stay, post-acute skilled care kind of patient. I think the risk adjuster I believe doesn't adequately measure that.

Thirdly, we find that the risk adjuster doesn't measure

accurately dually eligible Medicaid patients, for whatever reason, whatever it is that we are missing in their regular care that affects their home health care episode needs to be better captured.

Secondly, I am a great believer that rehospitalization and emergency room use are very important outcomes to measure here. But right now I know that from my own organization, a lot of our clinicians don't fill that out in OASIS because they often do not know why someone ended up in the ER. They really can't say that it was directly related to whatever the episode had to do with. So they don't want to put in inaccurate information.

We actually did an interesting study of rehospitalization rates and we found tremendous variation. In fact we have one hospital that has very high rehospitalization rates and another that has very low rehospitalization rates. So the question becomes, to what degree can we control rehospitalization, or does it have to do with patterns in the hospitals themselves?

In addition, we find that in certain parts of our urban area where people do not have a primary care physician or any ongoing relationship with a physician, we are more likely to send that person to the emergency room. And that's a good thing. Very often we have to get that person seen and if we do not have a physician to refer them to, that is the right clinical decision. But that raises your emergent care rate, and we would never want to have a situation where you avoid doing that because it's being measured and it can affect you negatively.

So there seem to be a number of issues that influence patterns around rehospitalization and emergent care that I think need more exploration and more testing and research. I think some of it is going on and you can lead us toward whatever it is that we can learn from that is ongoing.

I do believe process measures are very important because part of what you do in home health is try to pick up things earlier. If someone is losing sensation in their feet, you want to pick it up early. You want to avoid complications. That is really one of the benefits to the Medicare system that we can bring. So I think it is important to try to get some process measures and I think there's some work there that can be helpful.

I do not know how to tackle the patient and family satisfaction. I've been racking my brains about it because I want to underscore what Sharon said, which is you see a physician for 15 minutes or half an hour and you have experience, which may be a good experience or a bad experience. When you have home health care, you have someone coming into your home for an extended period of time. Capturing that patient and family experience I think is very central to quality, because it is much more than an intervention. It is much more really dealing with a whole set of issues. The patient has a very personal experience.

I do not how to do it. I do agree with you, the global, how did you feel about your home care experience generally yields very high satisfaction rates. We've been doing something with Press Gainey which has been painful but has really tried to break

it down to a lot of subcomponents and we've learned a lot. But I think we have to think about, down the road, trying to capture that because I think it is a very important quality measure for the Medicare program as a purchaser of care.

Then the only other thing hat I have been thinking about, and I do not how to get at this, we just looked at some thinking on the SNFs, and the Commission has been trying to do some work toward integrating post-acute care. I'm wondering if there isn't some way to think about that. For example, when we looked at SNFs we talked about pain levels. We talked about delirium. There are the same issues in home health, trying to really reduce pain and discomfort. We get a lot of people coming out of the hospitals with high levels of delirium.

So I think maybe we should also at least take some steps toward consistency of quality measures here as we try to think about ways to integrate and compare post-acute care sites.

MS. CHENG: Just to hit on that, one of the measure sets that the National Quality Forum collected and considered was a measure set that has been developed by the National Hospice Care and Palliative Care Association. It was measures of, did you to achieve comfort and pain alleviation? That's a set, if you would like staff to look at, we could.

MS. RAPHAEL: They did something that probably some people here know, they actually give patients a face and you actually put in how you feel, your grimace level, and that is how it is scored.

DR. CROSSON: We have looked at the ACOVE measures in our own organization. Earlier this year I was on a reactor panel when they were released so I spent time with our geriatricians, who are by and large very enthusiastic about them, for the same reason that Carol mentioned, that they seem to feel that many of them are a linchpin to prevention. Some of those linchpins are just not being done in common practice, and I think the ACOVE that was published bore that out.

On the other hand, if you look at the study it was rather expensive to get the data on a relatively small number of patients because it involves rather tedious chart review. So one of the things that we're looking at is to what extent can at least some of them be accessed from existing data systems, including the clinical systems that we're going to put in place, or to what extent can we modify clinical systems to get at the information?

So the question is, if they are that valuable and if that is what the folks feel, to what extent when applied to home health care could they be done in an efficient way? And to what degree are they modifiable or what? Or is there a cost trade-off there that is not going to work?

DR. MILLER: When we discussed this ourselves internally, the very set of thoughts that you're going through now were one of the conversations that we were having. That if you to move to these process measures and to pick up some of the ACOVE stuff you would have to be thinking about a different mechanism to pick them up, because I think if it comes from chart review it's a real barrier. But Sharon has had the thought herself.

MR. BERTKO: I just would only add something there, that I know the RAND researchers who have been looking first at chart reviews are now trying to find proxies for quality measures that would come through administrative systems and there is some work being done.

DR. WAKEFIELD: Could we at some point see the overlapping measures that you said existed between NQF on the OBQIs with AHRQ. I don't know that I saw AHRQ's ten. I believe you said that there were 10 measures that they converge around.

MS. CHENG: I didn't want to read all 10 but I will pass them along.

DR. MILSTEIN: I'm struck by the fact that with the acknowledged imperfections we do have a set of quality measures here that have been both approved by the National Quality Forum, which has a pretty structured process and multi-stakeholder involvement, as well as AHRQ. So I think this pushes right back to where we were on the prior discussion which is -- I call is the all things considered question. All things considered, imperfections in the current measures, the advantages of waiting versus the disadvantages of waiting, do we have enough for openers, as it were, to begin?

Again, if we use the 10 process measures that we are now using for measuring all hospital care, the question is, are we at least no worse off than using the 10 process measures that we are currently using for hospital payment?

MS. RAPHAEL: The strongest part of this, if we can get the risk adjuster right, seems to be on measuring functional outcomes. The OBQI part of it seems to have the greatest strength. Then I think the question would be, is it enough to go with that when you do not have the adverse events yet in a state, and you don't have the process measures? That would be, to me, a question that the Commission would be to answer. Do you feel if you have one of three prongs here, and hopefully with a risk adjuster in good enough shape?

MR. HACKBARTH: Let me turn it back as a question. If you just have one of the three prongs, I think the essence of what Arnie is saying is, are you going to make the world worse by proceeding with one of the three prongs or will you move modestly in the right direction and keep momentum going?

MS. RAPHAEL: I would want the risk adjuster to be in better shape. While I could wait on the process measures, I would want the whole rehospitalization and emergent care to pay better understood, because I consider those really important outcomes. So I don't know enough about what research or the state of research in those areas.

MS. CHENG: Are your risk adjustment concerns on the OBQI and the OBQM, or do you see a difference?

MS. RAPHAEL: The OBQI, I think. On both. I do not know enough about it, but I know there are some real concerns about it.

DR. WAKEFIELD: Do those concerns translate to the 10 measures that we see congruence between AHRQ and NQF on, do you know?

MS. RAPHAEL: I don't know.

DR. WAKEFIELD: I'm back to Arnie's point and what I asked to take a look at where we're seeing that, what that set of 10 happens to be. I guess probably it would be useful to go back to AHRQ and/or NQF and see the extent to which they looked at risk adjustment. To Arnie's point, they're just terribly thorough it's hard to imagine that they did not assess that. We certainly did in the other NQF work that I've been involved with on hospital performance measures. So it would be nice to have that information.

MR. HACKBARTH: Any others?

DR. NELSON: But risk adjustment isn't so critical is you're talking about quality improvement. It is very critical if you are talking about rewarding performance with payment differences, because it can lead to adverse selection if you don't have it right.

DR. MILSTEIN: I hope I'm interpreting these QI measures correctly, but as I understand how they are using QI, they're not using it in the sense of whether or not the home health agency improved. They are using it to track patient improvement, which is a little different use of the term QI than one that we are used to I think.

MR. HACKBARTH: Generally speaking, isn't it true that if you are trying to measure outcome, that then there is extra weight on having appropriate risk adjustment for the different start place of the patients. If you are measuring process steps then risk adjustment is less of an issue. So to the extent that these are measuring the outcomes of patients then risk adjustment is relatively more important, although I guess I'm with Mary, it seems to me that the National Quality Forum and AHRQ are quite sensitive to these matters and I think it really bears looking into whether they considered adequacy of risk adjustment in their evaluations. I would think they did but I don't know that for a fact.

DR. REISCHAUER: As Arnie says, this is an imperfect exercise we're in and the question in my mind is, even if we can do it rather poorly, sending signals is important. Signals not necessarily with respect to home health but with respect to Medicare overall, and looking down the array of Medicare providers and benefits and saying which are close to prime time for this and let's let them out on the stage for an overture. It can be not a whole lot of money, but it's very symbolic.

In listening to what people are saying I've come to the conclusion that we are not running a bigger risk here that we're going to make things worse off. The risk is that we're not going to reward all the people who should be rewarded. But that is okay because they will begin to scream, and that is what causes measures to improve is the howls of injustice that prove to be justified. So I would go ahead.

DR. WOLTER: I might just tack on to that. I do think there's some value in tying some amount of payment to reporting of the measures. And if we did want to make the comparison to the hospital reporting, not only is the payment tied to reporting 10 relatively narrow measures, but it is not tied in any way to the results. In other words, the reporting in and of itself, at

least at this moment in our evolution, is really triggering the payment. I think we all would agreed that is not adequate. We've talked about, should reporting be a condition of participation, and really the payment itself then is only triggered when certain results are achieved. But getting started I think does have a tremendous amount of value and certainly this will evolve over time into something more sophisticated.